COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

September 14, 2015
COPIC, Mile High Room

Meeting Summary

Commissioners Present: Bill Lindsay (Chair), Cindy Sovine Miller (Vice Chair), Elisabeth Arenalas, Sue Birch, Jeff Cain, Greg D'Argonne, Ira Gorman, Marcy Morrison, Dorothy Perry, Chris Tholen, Jay Want
Absent: Rebecca Cordes, Steve ErkenBrack, Linda Gorman, Dee Martinez, Marguerite Salazar, Larry Wolk
Staff: Lorez Meinhold. Johanna Gibbs and Cally King (Keystone)

Action Items/Follow-Up:

- Keystone to revise transparency language based on Commissioner feedback for the Recommendations and Parking Lot Item document to be shared back out.
- The Planning Committee and Keystone will work on specific workforce recommendations based on Commissioner direction to follow-up on at the next Commission meeting, Friday, Sept. 25th.

Next Meeting: Friday, September 25th, 12:30 – 3:30pm at COPIC

Meeting Summary:

I) Approval of the Minutes

A) Elisabeth Arenales provided a motion for approval, pending revisions to the August, 28, 2015 meeting minutes.
   1) In section 4, page 2 of the minutes, it should be noted there is evidence to support the notion that if data is more transparent, it does effect behavior.
   2) On the last page of the minutes, page 6, section A on the "November report outline" is murky and needs more detail on the conversation. The conversation did not intend to portray that "the final report will not be very long," instead the discussion really meant the timeline to complete the report was short, not the length of the actual report.

B) The August 28th meeting minutes were approved without objection, including the revisions.
   1) Jeff Cain wanted to ensure there is time for stakeholders to review and comment on recommendations.

II) Planning Committee Memo - Bill Lindsay / Commissioners

A) The Planning Committee will begin providing memos and updates from their meetings, in addition to the meeting minutes, to keep Commissioners apprised of the conversations and things going on within the Committee. This effort is also to keep the public better apprised of what is going on within the Planning Committee.

B) The memos and minutes from each Planning Committee meeting are posted and available on the Commission's website under "Resources" > "Documents."

III) Transparency Language, Recommendations and Parking Lot Items - Commissioners

The complete Transparency Recommendations and Parking Lot Items identified by the Commission can be found on the Commission's website under "Commission Meetings."

A) Commission Discussion:
   1) The Commission notes and recommendations should reference that transparency reduces spending if prices/ costs are known to provider at point of care. When pricing is available at point of care it also incentivizes quality.
      (a) The Commission is not ready to recommend payment reform at this time because we have not yet taken that up, and would suggest holding off on any recommendations related to this topic until we can discuss payment delivery reform.
   2) With regards to additional resources for APCD, it should be moved into recommendations stating that, "the Commission would like APCD to receive all the funding necessary."
      (a) The Commission had decided at the last meeting that instead of assuming APCD needs more funding, we would ask CIVHC about their needs and see if this is something we do need to make a recommendation on.
      (b) Language should then read, "Ensure APCD has all necessary resources to accomplish goal of maximizing the availability of data."
      (c) How would this be enforceable?
         (i) If there is an opportunity for the scholarship fund to be expanded, it would allow APCD to get more data out there.
      (d) The literature seems to support the idea that APCDs increase transparency; if the Commission supports that premise, we should make a recommendation to support the APCD.
         (i) There is proven data showing that when cost data is combined with payment systems that incent value, providers choose in a way that increases quality and decreases cost.
   3) The recommendations should better capture the notion of data transparency and what the data needs to be for consumers to make informed decisions; when consumers take on financial responsibility, they need information to make timely and informed decisions.
   4) Can the Commission have a conversation about process and how to move items from the parking lot to recommendations? When there was a comment earlier that we are not yet ready to talk about payment reform, it should be included in the parking lot.
      (a) The "parking lot" for this conversation is referring to specific items under the topic of transparency that the Commission was unable to discuss or did not have the time to further develop. The suggestion to look at payment reform has been noted and belongs under a different list for future Commission discussion.
   5) The Transparency "background" segment in the Recommendations and Parking Lot Items document needs some revisions:
      (a) When we mention "data to primary care providers," why do we limit it to primary care? Shouldn't specialists be included as well? Should the wording be changed to "provider" or "clinician" to provide more clarity?
      (b) Also important to note in the background that "transparency alone was not enough."
         (i) On the contrary, it seems transparency does work across the system. It also seems clear that differences need to be better defined for those with one form of payment opposed to those using Medicaid. Transparency does help move the ball forward and the Commission needs to make a general statement about the importance of transparency.
   6) Wordsmithing may not be the best use of Commission time, can we trust Keystone to take our thoughts and provide the document back to the Commission?
         (i) It is important to go through this process so all Commissioners agree with what is placed in the final report.
B) Review of transparency recommendations submitted prior to the meeting from Commissioner Linda Gorman who was unable to attend the meeting (see Appendix A):

1) I agree with points 1 and 2, around providing fees as a line on item on patient bills, and would like more conversation around why these can't be included.
   (a) It seems difficult to understand how some of these items, like taxes assessed to coverage providers, could be included as a single line item on a patient bill. How would the expense be divided among a multitude of clients with multiple bills?
2) Point 3 - suggestion Medicaid consider sending an explanation of benefits to clients when they incur a charge - does seem like it would cost a lot, but curious how it might work if implemented.
   (a) The Office of Health Care Policy & Financing is looking at modernizing their processes to avoid fraud, but there isn't a mechanism yet for client fraud which won't be in line for a few more years. With regards to provider fraud, HCPF has sophisticated information to monitor provider fraud. This recommendation seems very cost prohibitive. Issues around fraud, waste and abuse should be included in the parking lot, not just fraud.
3) Point 4 - creating a path to licensure for American citizens licensed elsewhere - standards for licensing physicians are held very highly and if we provide an alternate path for folks to come back and practice, we need to make patient safety remains the overall, number one priority.

C) **Next Steps:**
1) Changes to the document will be shared with the rest of the Commission for their input (ACTION).

D) **Public Comment:**
1) George Swan, retired hospital administrator: Has anyone opened up and looked at the pivot tables I submitted? I hope you're finding it useful and your feedback is always helpful. I would also like to share with you that I now have a different perspective on the healthcare system that I didn't expect. I recently had a colon screening that came back positive. I have a rare and incurable cancer and was in the hospital at St. Joseph's for three days. While in the hospital, I opened some pivot tables and found that St. Joe's has some of the highest satisfaction scores in the country. You get a new perspective in the hospital as patient (instead of as the hospital administrator) and I have some recommendations for the Commission to consider. 1.) Disease registries - there is a Ted Talk by Stephan Larsson on the importance of disease registries for best and worst practices which can help to change hospital practices - the availability of information in Colorado on diseases is not very good. 2.) The literature doesn't show cost benefits from transparency registries; the literature says the transparency we have is poor. 3.) Consumer engagement - the SIM project is working on Consumer Engagement; additionally, the state could look at PERMA - 5 factors of optimal well-being by Dr. Seligman – and Colorado could be the first state to produce a regular practice of PERMA surveying and reporting.
   (a) Commissioner question: Did transparency enter into your decision making on where to receive your health care?
      (i) I found information from reading scientific studies. The transparency wasn't zero, but there was a lot of information lacking and there are some simple ways to substantially increase transparency.

IV) Workforce Presentation - Ira Gorman / Commissioners

A) Commissioner Ira Gorman provided a presentation on workforce and the various factors of how the health care workforce may, or may not, increase health care costs. The workforce presentation can be found here or on the Commission's website.

B) Commission Discussion:
1) It is implied that cost is affected because there is a shortage of Primary Care Providers, but is it possible people use PCPs opposed to specialists because they don't want to run around to a lot of different providers?

(a) The answer depends on different factors including geography and the availability of specialists opposed to PCPs. It can also work where consumers see the wrong specialist, like in the back issue reading from Virginia-Madison, where patients are provided services they don't need to resolve their issue.

2) When we talk about a specialist providing primary care, are we talking about a specialist who provides certain primary care services because they are interrelated, or a specialist who provides the whole suite of services typically done by a PCP?
   (a) It all depends on the situation and what is available at the time.
   (b) When presentation says "two in five" are getting primary care services, "services" implies portions on primary care services or part of their primary care, but not the whole spectrum of service.
3) What is a group based visit?
   (a) When you have a group of individuals with the same disease or symptoms, you can provide education and answer questions within the group. It is a more efficient way to deliver services, as long as they are following patient confidentiality laws.
4) Do we want to focus on the financial aspect of workforce or look at other portions?
   (a) I work in primary care and love what I do. It's tough work and it's not just about pay. Primary care providers choose our work because we like developing relationships and working within our communities.
5) The Commission eventually needs to get to a conversation on Team Based Care. We can't delve into it during this discussion, but it is a significant issue.
   (a) We can include this in the parking lot to point to a topic that is important to delve into, but one this Commission doesn't have the time or resources to more fully research and discuss (ACTION).
6) Review of workforce comments submitted prior to the meeting from Commissioner Linda Gorman who was unable to attend the meeting:
   (a) Looking at expanding efficiency and effectiveness of PCPs so lower input activities are completed by someone at a different level of licensure and leaving the more complicated activities to physicians - doesn't this imply we are replacing physicians or employing people at the same level?
      (i) Correct, it is changing the delivery models and using workforce in a more efficient manner than at present. There is a shortage of PCPs and the bottom of the pyramid should be pooled upwards; there should be a lower number of specialists or more PCPs. In some instances, it is easier to get an appointment to see a specialist than a PCP.
      (ii) We should talk about more "team based care" in a more thoughtful way. There are states that have done this well in creating more positions for PCPs. Our job is to provide a way to get everyone effectively caring for our population.
   (b) The comment concerning medical schools is interesting, there seems to be some decisions made at that level of how many students are accepted in medical school, but there's not a national organization to say what is needed as far as workforce needs down the pipeline.
      (i) The residency system is also not given national oversight on where the workforce needs are in the country.
7) Recommendation placeholders:
   (a) The Commission has talked about PCPs, specialists, Nurse Practitioners and Physician Assistants but we haven't talked about the other members of the care team that are also in shortage (lab techs, x-ray techs, etc.).

V) **Office of Primary Care: Report and Overview of Work -** Steve Holloway, Director, Office of Primary Care, Colorado Dept. of Public Health & Environment

A) Steve Holloway provided an overview of the Office of Primary Care within CDPHE and their workforce plan to help address issues of supply and demand for health care workers. The presentation can be found here or on the Commission's website.

B) Commission Discussion:

1) Seems like a great plan on cost vs. accessibility, but there's not a lot of data. Is there any data in Colorado correlating lack of access leading to higher cost?
   (a) Not a specific area I'm aware of in Colorado but there is a lot of data about conditions that get more expensive the longer you wait to treat, i.e. diabetes or behavioral health.
2) When I think about physician shortages and current contracting practices, I wonder whether we're talking about in-network or out-of-network issues, or provider shortage issues.
   (a) When you look at licensed dentists practicing in Colorado, you get a dentist/patient ratio of about 1:1900 which would indicate an oversupply, yet dental services are cited as one of the most delayed or deferred medical treatments in Colorado for a variety of reasons. Only about 40 percent of adults have dental insurance in Colorado and many private dentists won't accept Medicaid. The question is both geographic and socioeconomic.
3) If there was one thing the Office of Primary Care would like to see the Commission to prioritize that could carry the ball further, what would that be?
   (a) The area of our plan where we have accomplished the most is related to workforce data. Our success was in part that we had a clear message on good policy and had partners inside and outside the sector to help push the project; we were also very conscientious about the criticisms of the program. The parts in controlling cost where we haven't been able to accomplish much with are around vertical and horizontal integration of all the workforce incentive activities to ensure they are working towards a common metric. The other area is towards the question if there is a better organized body to help organize all this work. In terms of demand, you can do a lot on the prevention side of things to lower costs. Often times the best spokespeople for these types of public health interventions are the clinicians within the community who can provide antidotes about their patients, anomalies witnessed, and needs for interventions in the community.
      (i) I heard you say, there needs to be an effective workforce policy body that collaborates and provides data sets and community needs assessments; I think this is very important. You also commented on payment issues, I think this would lead towards value based plans, making certain Medicaid continues looking at PCP needs. Graduate Medical Education is also important to look at, their rules are cumbersome and could use a state based request for more leniency on some of those requirements.
4) As far as comprehensive workforce, Virginia and Maryland have great state based programs to look at. I've also read that when loan repayment programs are extended, you can keep physicians in those communities a little longer.
   (a) The Office of Primary Care only does three year service contracts that are renewable for up to five additional years for service credit; the Federal government usually does a two year service contract. Three years seems to be the tipping point to attracting the right providers into the program and we do have an end goal of attracting the right folks who ultimately will want to stay and work in those communities.
   (b) Is the time commitment also be a barrier to the program?
      (i) It could be, although we do receive more applicants than we have money in the program. We look for applicants who we think could commit to the time and service needed for lower income and rural communities. We don't necessarily want to fund 100

percent of applicants every time, but would like to be able to fund 50 percent of applicants all the time.

(c) Might want to refer to program as "debt reduction" opposed to "loan repayment" to help differentiate between different types of scholarship programs.

5) One observation, I liked having the suggested recommendations at the end of the presentation – perhaps we should include this section for presenters moving forward. Looking at reimbursement issues, that topic may be beyond the Commission's purview and could be included in the workforce parking lot. (ACTION)

VI) Commission discussion following Workforce presentations - Commissioners

A) Disappointed this was a very physician-centric conversation; in the future, would like presentations that focus on all types of health care workers. There is a shortage in Colorado that is getting worse, part of which is due the rising cost of living and housing costs. I think we are looking at a fairly significant issues for both lower and higher paid health care professionals.

B) This is a complex issue that doesn't lend itself to simple solutions or analysis; there is also limited data available to make recommendations.

1) If we have time set up an advisory committee there are lot of individuals and organizations who could talk about this issue, I am also thinking about long-term care workforce in this context.

C) Also interested to look at why nurses who are graduating with degrees can't get hired by the hospitals because they don't have experience, even though there is a nursing shortage.

1) Also need to look at residency experiences of Nurse Practitioners in non-hospital environments.

D) We should look at care delivery models, i.e., project ECHO program, the Jeffrey Bender model, etc.

E) Next Steps: Planning Committee will work with Keystone for specific recommendations to follow-up on at the next Commission meeting (ACTION).

F) **Public Comment:**

1) Colleen Casper, Colorado Nurses Assoc.: Great conversation and presentations on workforce. From a workforce perspective, there are a lot of people who spend money on this and there are people who can influence that content on training. Would like to complement HCPF for making pathways for non-provider physicians to increase access.

2) Dr. Julie Kirgan (comment submitted online, 9/13/2015): My comment is regarding the issue of increasing of shortage of the physicians in the USA and measures to resolve this problem. I am an MD from Russia. I have passed all USMLEs including step 3. I am ECFMG certified. I was not able to secure the residency spot to complete the licensing process due to my years of graduation after medical school (more than 15 years). Majority of residency programs require no more than 5 years after medical school graduation to be considered. I am MD who is wasting my experience and knowledge in this country that will not allow me to practice medicine in spite of shortage of physicians. There should be some other pathways for experiences IMG who graduated more than 5 years ago to practice their earned profession and be a value member of the society.

(a) Steve Holloway: PCO has an international program; however, in Colorado we are disadvantaged for international medical grads because we have fewer slots to fill in our residency programs and rarely fill them with international medical graduates.

3) George Swan: Excellent discussion. I have downloaded data from CHI on workforce into a pivot table that I can share to be put on the website. CHI receives their data on licensing from the Colorado Dept. of Regulatory Agencies which provides insight on community resources and engagement. There are two things I didn't hear for the parking lot: Health Plan Design including cost awareness – the Commission could look at Kaiser's health plan design and Whole Foods

employee provided health care; and CORHIO, it blows me away that Kaiser doesn't submit their records into a state based health information exchange.

VII) Updates - Bill Lindsay/ Commissioners

A) New November and December Commission meeting dates due to the holidays:
   1) Monday, Nov. 16th from 1:30-4:30 at COPIC (replaces meeting on Friday, 11/27)
   2) Monday, Dec. 21st from 12-3pm at COPIC (replaces meeting on Friday, 12/25)

B) Milliman – Analysis of Physical Therapy co-pays
   1) There had been issues working out the contract with Milliman; the issues have been worked out and Milliman has started their work which may be delayed from the original anticipated deadline.

C) Schedule of Presentations
   1) Commissioners were provided with a schedule of presentation topics and Commissioner assignments.

D) November report timeline update
   1) The Commission must submit their first report to the General Assembly in November. The Planning Committee is working on deadlines for Commissioners. The goal is to have the draft completed for the Commission to review from October 9th-23rd and provide any revisions or comments. Revisions will be compiled and taken to the Planning Committee on November 2nd for incorporation into the final report which will be submitted to the General Assembly by Monday, November 16th.

E) Stakeholder questionnaires
   1) Questionnaires have been sent to stakeholder groups to solicit their comments on health care costs as related to the Commission's work. Completed questionnaires have started to come in; the Commission will look at the responses and would like to try to coordinate presentations from stakeholders that complement the Commission's topic discussions.

Meeting adjourned at 3:30pm

Appendix A: Transparency suggestions from Commissioner Linda Gorman

From: Linda Gorman
Date: September 11, 2015 at 3:14:25 PM MDT
To: Bill Lindsay
Cc: Lorez Meinhold
Subject: Transparency suggestions

Bill,

At the last meeting I attended (the one before last) you asked Commission members to submit one or two suggestions for transparency that were clear, short, and report ready.

Here are the ones that have occurred to me so far:

1. The legislature should reverse laws prohibiting hospitals from listing the provider fee as a line item on patient bills. Transparency requires that costs that government creates be obvious as well as those created by the private sector.

2. Groups that provide coverage should be able to list any fees/taxes assessed by the state or the health exchange on their premium notices as a separate line item. The state should never act to suppress information about health care costs.

3. Medicaid should considering sending an explanation of benefits to clients when they incur a charge. My understanding is that it doesn't at present. Obviously it might cost more for the state to do this, but it might also end up saving the state money. Fraudsters use a client's identity to bill Medicaid for services that were not rendered. There is no reporting on this because the person never knows. It should at least be something up for discussion. Returned statements might also provide information on whether people for whom managed care fees are being paid are still resident.

4. Groups that license physicians and others should detail a path to licensure for American citizens who were licensed physicians elsewhere but have been out of medical school for a while. At present, an experienced physician who moves here after practicing for, say, 10 years in Norway, has no way to get a license without going back to medical school. It is a waste.

On another topic, when it comes to reducing health care costs, I think we should note that the state exchange adds millions of dollars a year to costs and could be replaced by the federal exchange for much less. Steve ErkenBrack may be able to provide good concrete reasons why this is a harebrained suggestion, but the November report could put that on the table as something to be discussed for possible savings.

Linda Gorman